The G8, Globalization, and the Need for a Global Health Ethic

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Introduction: Why study the G8 and global health?

In 2001, colleagues and I[1] began the first 'report card' on how the actions and policies of the G7/G8[2] affected population health, in particular the health of populations outside the high-income countries (Labonte & Schrecker, 2004; Labonte, Schrecker, Sanders, & Meeus, 2004). The focus on the G7/G8 was and is justified for at least two reasons.

First, the G8 countries 'account for 48% of the global economy and 49% of global trade, hold four of the United Nations' five permanent Security Council seats, and boast majority shareholder control over the International Monetary Fund (IMF) and the World Bank' (Corlazzoli & Smith, eds., 2005, p. 5). They provide roughly 75 percent of the world's development assistance; their deep pockets, organizational resources and superior bargaining power provide them with formidable advantages in trade negotiations and dispute resolution proceedings; and firms located within their borders have until recently been the primary sources of outward foreign direct investment (FDI).[3] The decisions their governments make, individually and jointly, have unavoidable impacts on literally billions of people outside their own borders, whether or not those impacts are intended.

Second, although the G8 came into existence (as the G6) in response to a number of shocks in the international economic environment and initially were concerned mainly with macroeconomic policy coordination, annual Summits and periodic ministerial meetings – in particular, meetings of finance ministers – subsequently emerged as comparably important in a variety of social and economic policy fields. According to John Kirton, a leading academic observer of the G8, Summits 'have value in establishing new principles in normative directions, in creating and highlighting issue areas and agenda items, and in altering the publicly allowable discourse used' (Kirton et al., 2006, p. 3). Acknowledging both the dominant role of the G8 in the global economy and the function of Summits as 'the only forum where heads of the major governments routinely meet' (Collier, 2007, p. 13), development economist Paul Collier presented his important book *The Bottom Billion* as a development policy agenda for the G8. Whatever normative questions surround the legitimacy and accountability of G8 Summits and ministerial meetings, which are briefly addressed in the concluding section of this chapter, the facts of G8 influence on global affairs are beyond serious dispute.

The report card work initially addressed commitments made at the 1999 through 2001 Summits, although subsequent publications updated the analysis to include the 2005 Summit at Gleneagles, which arguably represented the zenith of G8 interest in development issues as of mid-2008 (Labonte & Schrecker, 2005; Labonte, Schrecker, & Gupta, 2005; Labonte & Schrecker, 2006; Schrecker, Labonte, & Sanders, 2007; Labonte & Schrecker, 2007a). We first considered the

extent to which G8 countries had lived up to their Summit commitments. However, we examined not only commitments that directly referred to health, but also commitments in a variety of other policy fields that affect social determinants of health (SDH): the conditions that make it relatively easy for some people to lead long and healthy lives, and all but impossible for others. These policy fields included education and nutrition; development assistance; trade policy and market access; macroeconomic policy and poverty reduction; and debt relief.[4] Furthermore, we examined not only the extent to which the G8 had fulfilled or complied with their commitments, but also the *adequacy* of those commitments when measured against the nature and scale of unmet needs and with the *appropriateness* of commitments, based on what is known about influences on health outcomes. In other words, we were and are concerned not only with whether the G8, individually and collectively, have done what they said they would do but also with whether they committed themselves to doing enough, and doing what the evidence indicates is necessary.

Globalization, development and health

Describing the health implications of Summit commitments and G8 policies outside the health care field requires that researchers 'work backward' from what is known about the elements of daily life that increase probability of illness or injury, while simultaneously 'working forward' from different bodies of evidence relevant to how policy choices and dynamics at the national and international

level influence those elements. For much of the world's population, the most important influence on those elements of daily life is undoubtedly transnational economic integration (globalization): societies rich and poor alike are becoming part of the global marketplace, in various ways and on various terms.

Globalization influences social determinants of health by way of multiple pathways that are often complex and contested (Labonte & Schrecker, 2007b). For instance, controversy surrounds globalization's implications for economic growth and poverty reduction. Over the long term, and with considerable variation at any given income level, richer societies are healthier (World Bank, 1993; Deaton, 2003) and socioeconomic gradients in health are present in societies rich and poor alike, with the relatively poor exhibiting poorer health (see Figure 1). If globalization could be shown to be reliable and effective in increasing growth rates and reducing poverty, then a strong initial presumption would exist that measures to promote globalization, such as trade liberalization, should be embraced for their health benefits (Feachem, 2001).

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However, the evidence that globalization contributes either to economic growth or to poverty reduction is at best equivocal, depending *inter alia* on how one assesses the extent to which national economies have been integrated into the global marketplace; how poverty is defined; and how many uncertainties about data quality one is willing to live with or overlook (Milanovic, 2003;

Satterthwaite, 2003; Reddy & Pogge, 2005; Kawachi & Wamala, 2007). Between 1981 and 2004, while the value of the world's economic output quadrupled, only modest poverty reductions were recorded even based on the World Bank's contentious $1/day and $2/day poverty lines.[5] The reduction in global poverty at the $1/day level is due entirely to poverty reduction in China, with gains elsewhere in the world being offset by increases in the number of poor people elsewhere, mainly in sub-Saharan Africa. Almost half the world's people, including 1.3 billion classified by the International Labour Organization (2008, p. 10) as employed, live on incomes at or below the $2/day income level. There was almost no change in the number of people worldwide living on $2/day or less; in this case, reductions in China were more than offset by increases in the number of poor people in south Asia and sub-Saharan Africa (Chen & Ravallion, 2007).

Indeed, at least during the post-1980 period economic growth proved remarkably ineffective in reducing poverty (Woodward & Simms, 2006); an innovative econometric study completed in 2007 suggests that globalization may actually have reduced the extent to which the growth that does occur is translated into improvements in health status (Cornia, Rosignoli, & Tiberti, 2008). Even globalization's enthusiasts concede that there may be substantial numbers of losers within national economies. Thus, the only responsible answer to questions about globalization and poverty reduction is that 'the net effects of globalization on the poor can only be judged on the basis of 'context-specific' empirical studies' (Nissanke & Thorbecke, 2006, p. 1340).

Even if the connection between globalization and growth were stronger, then, promoting globalization would not fulfil the commitment made by the G8 in 2001 to 'make globalization work for all [their] citizens and especially the world's poor' (G8, 2001, ¶3). Once almost heretical, this perspective has now entered the mainstream of development policy discourse – notably, by way of a number of recent research syntheses and consultative processes. The International Labour Organization's World Commission on the Social Dimension of Globalization (2004) organized its recommendations around the idea of 'fair globalization' and addressed *inter alia* the need for reform of trade, the international financial system, labour standards, and development financing. In its 2005 report the UN Millennium Project, established as an advisory body to the Secretary-General, mustered a prodigious amount of evidence to support its arguments for organizing development assistance, trade policy, and scientific research around the imperative of achieving the Millennium Development Goals (MDGs) derived from a resolution passed by the the United Nations General Assembly in 2000.[6] Also in 2005 the multinational Commission for Africa, convened by the British government as part of the lead-up to the 2005 G8 Summit, argued for similar reforms with specific reference to the development needs of sub-Saharan Africa (Commission for Africa, 2005). The United Nations Development Programme (through annual Human Development Reports) and the UN's Department of Economic and Social Affairs, although somewhat marginalized within the UN system, nevertheless continue to demonstrate the incomplete and unequally distributed benefits of globalization. In this they are joined by a growing number

of social scientists who recognize the 'disequalizing' dynamics of the global marketplace and the 'asymmetrical' distribution not only of its benefits, but also of the ability to influence its rules and institutions (Birdsall, 2006a; Birdsall, 2006b).

As production has been reorganized across multiple national boundaries (Dicken, 2007), genuinely global labour markets have emerged. National and sub-national jurisdictions can be played off against one another based on labour costs and 'flexibility', and redistributive policies are constrained by the possibility of disinvestment and capital flight (Williamson, 2004; Evans, 2005; Mosley, 2006). Cerny has described this dynamic in terms of pressure for policy convergence toward the competition state, focused on 'promotion of economic activities, whether at home or abroad, which will make firms and sectors located within the territory of the state competitive in international markets' (Cerny, 2000, p. 136). The rise of the competition state is accompanied by far-reaching redefinition of citizenship rights, which even in formal democracies are increasingly held not by individuals as members of a polity but rather by transnational corporations (TNCs) and players in the global financial markets. 'These markets can now exercise the accountability functions associated with citizenship: they can vote governments' economic policies in or out, they can force governments to take certain measures and not others' (Sassen, 2003, p. 70; see generally Sassen, 1996). A parallel development, albeit structurally related, is the infusion of the logic of the marketplace into domestic economic and social policy. Individuals and households, like sectors of national economies, are expected to 'earn their

keep' in the new global environment. Social policies are organized around the anticipated return on investment in "human capital" (Giddens, 1998; Jenson & Saint-Martin, 2003; Molyneux, 2007) and citizenship is redefined within national borders in terms of effective participation in the domestic and global marketplace as a producer or consumer.[7]

The G8 and health: challenges

The assessment presented here concentrates on official development assistance (ODA), debt relief, trade policy and support for health systems. These are by no means the only areas of G8 policy that are relevant to population health, but taken together they strongly influence both the volume of resources available to meet basic health-related needs such as those related to income, nutrition and education in much of the developing world and the policy environment for meeting those needs, to the point where shortcomings in these areas are unlikely to be offset by initiatives in others.

An immediate need exists for increased resources to support national health systems (Schieber, Gottret, Fleisher, & Leive, 2007; Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008). Despite substantial increases in development assistance for health in recent years, publicly financed health systems in low- and some middle-income countries remain drastically underfunded relative to the costs of 'a rather minimal health system,' estimated by the World Health Organization's Commission on Macroeconomics and Health (Commission on

Macroeconomics and Health, 2001) as $34/capita ($40 in 2007 dollars). By comparison, annual per capita health spending from all sources, public and private, in the Least Developed Countries (as defined by the United Nations) where 770 million people live is $15 (World Bank Health, 2007)). To provide basic health care, such countries will need to rely on infusions of external resources well into the future. Jeffrey Sachs, who chaired the both the Commission and the Millennium Project, estimates that poor sub-Saharan countries might be capable of generating US $50 per capita in total annual public revenue, out of which ' [t]he health sector is lucky to claim $10 per person per year out of this, but even rudimentary health care requires roughly four times that amount …. Foreign aid is therefore not a luxury for African health. It is a life-and-death necessity' (Sachs, 2007). His argument is not relevant only to sub-Saharan Africa: think for example of Haiti, the poorest country in the Western Hemisphere, or Vietnam, where public sector spending on health care was just US $4/capita as recently as 2001 (United Nations Country Team Viet Nam, 2003).

A similarly savage arithmetic applies to the need for development assistance more generally. The Commission for Africa and the Millennium Project each argued that approximate doubling of the industrialized world's development assistance spending *circa* 2005 was needed and justified within a relatively short time frame. Each body acknowledged recurring (and legitimate) concerns about the effectiveness of aid, but emphasized *donor* rather than recipient policies and practices as constraints on aid effectiveness, the Millennium Project noting *inter alia* that 'the notion of taking the [Millennium Development]

Goals seriously remains highly unorthodox among development practitioners' *because of* a lack of financial support from the industrialized world (UN Millennium Project, 2005, p. 202; see also p. 59). If nothing else, these and related findings (see e.g. Collier, 2006a; Collier, 2006b) should have shifted the burden of proof to the aid sceptics: those who claim that improvements in health can be achieved without substantial and predictable increases in aid flows. They do, however, leave open an important question about whether aid's effectiveness should be assessed primarily with reference to its contribution to economic growth, or rather with reference to its contribution to meeting basic needs. While the Millennium Project emphasized the importance of using aid more effectively in support of the MDGs, the effectiveness of aid is frequently equated with its contribution to economic growth; indeed Killick (2005, p. 19) argues that *less* attention should be paid to the MDGs and poverty reduction, and more to 'promoting the development of directly productive sectors.' Here as elsewhere, the need exists for an explicitly normative perspective on development policy choices.

External debt has been recognized for at least two decades as undermining developing countries' ability to meet basic needs (Cornia, Jolly, & Stewart, eds., 1987; Cheru, 1999). One of the most serious constraints on aid's effectiveness is that 'dozens of heavily indebted poor and middle-income countries are forced by creditor governments to spend large parts of their limited tax receipts on debt service, undermining their ability to finance investments in human capital and infrastructure. In a pointless and debilitating churning of

resources, the creditors provide development assistance with one hand and then withdraw it in debt servicing with the other' (UN Millennium Project, 2005, p. 35; see also Figure 2.) With this observation, the Millennium Project reinforced numerous earlier critiques by academic researchers and civil society organizations. Debt relief does not automatically bring about increased expenditure on basic needs, although this has happened in some countries following the past decade's multilateral initiatives (Gupta, Clements, Guin-Siu, & Leruth, 2002). Much more needs to happen, not least because of the relatively modest increase that even complete debt cancellation would provide in the revenues available to many governments in low-income countries (Schieber et al., 2007). Like increased development assistance, easing the debt burden of developing economies is best viewed as a necessary rather than a sufficient condition for improving access to basic needs.

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Then there is trade. Development policy protagonists who disagree about much else agree that improving market access for developing country exports is indispensable for growth, poverty reduction and associated improvements in social determinants of health. Researchers and many developing country governments attach special importance to eliminating agricultural subsidies that lower world prices and limit developing country export opportunities (Watkins & Fowler, 2002; Commission for Africa, 2005), although the actual magnitude and

distribution of benefits from agricultural trade liberalization remains uncertain (Wise, 2004; Birdsall, Rodrik, & Subramanian, 2005; McMillan, Zwane, & Ashraf, 2006). Within the industrialized countries agricultural subsidies are often justified in populist terms, yet they mainly benefit the richest agricultural producers and agribusiness firms (Commission for Africa, 2005, p. 279-284; United Nations Development Programme, 2005, p. 130). Both within and outside the agricultural sector, a source of special concern is the tendency of industrialized countries to apply much higher tariffs (tariff peaks) to labour-intensive exports, which are of special importance to many developing countries, than they do to raw or semi-processed commodities (IMF Staff, 2002). The irony is bitter because some developing countries have destroyed domestic industries by opening their markets to imports, accepting the resulting social dislocations as the price of global integration (Jeter, 2002; Atarah, 2005). The research literature does not appear to include a systematic inventory of such cases, suggesting an important area for future research.

A further dimension of the relation between trade and SDH, one widely neglected in the country-specific research literature, involves the effects of tariff reductions. Tariffs are an important source of revenue for many low- and middle-income countries, as they were for today's high-income countries before and during the early stages of their transition to industrialization.[8] The best available research shows that many middle-income countries, and especially low-income countries, have been unable to make up from other sources more than a fraction of the tariff revenues lost from trade liberalization (Baunsgaard & Keen, 2005; see also Aizenman & Jinjarak,

2006).[9] Commitments under the General Agreement on Trade in Services (GATS) or in a proliferation of bilateral and regional trade agreements may open up health care as well as services such as water and sewage treatment to private investment, 'locking in' privatization and its associated barriers to access to services by the poor and economically insecure. Finally, despite an interpretation of the Agreement on Trade-Related Aspects of Intellectual Property (TRIPs) that apparently preserves flexibility in response to crises such as the AIDS epidemic, it is far from clear that intellectual property rights have been removed as a barrier to ensuring access to essential medicines 'on the ground' in developing countries (Haakonsson & Richey, 2007; Kerry & Lee, 2007; United States Government Accountability Office, 2007; Correa, 2008).

The G8 and health: responses

The G8 Gleneagles commitment to double development assistance to Africa by 2010, a promised annual increase of $25 billion, was driven primarily by the European Union (EU). Although aid spending in 2005 increased, it included major one-off debt cancellations for strategically important and oil-rich Iraq and Nigeria. The industrialized world's overall development assistance spending fell by 5.1 percent in 2006, and by a further 8.4 percent in 2007 (OECD Development Assistance Committee, 2007; OECD Development Assistance Committee, 2008). The OECD's Development Assistance Committee warned in April, 2008 that 'most donors are not on track to meet their stated commitments to scale up aid;

they will need to make unprecedented increases to meet their 2010 targets' (OECD Development Assistance Committee, 2008).

Provision of health care and public health interventions is likely to be one casualty of failure. The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria is the G8's flagship global health initiative, established in recognition of the need to mobilize additional resources and to find more effective ways of delivering those resources. Although the G8 claimed at the 2001 Summit that the Global Fund would 'make a quantum leap in the fight against infectious diseases and … break the vicious cycle between disease and poverty' (G8, 2001, ¶15), the Fund lacks a stable, long-term financing mechanism; it relies instead on periodic replenishment meetings where it essentially passes a hat among donors. Over the 2005-2008 period, the G8 failed to make commitments that would provide a long-term funding base for the Global Fund. It could be argued that the 2007 promise to 'provide predictable, long-term additional funding in the ongoing replenishment round' (G8, 2007) was partly met at the September, 2007 replenishment meeting that elicited pledges of $9.7 billion for the period 2008-2010: an improvement over previous commitments, but this amount is still far below the Fund's anticipated resource needs of $12-18 billion for the period (Global Fund to Fight AIDS, 2007). Furthermore, former UN Special Envoy on AIDS Stephen Lewis warned in 2006 that 'what is happening, in a very insidious way, is that African governments are being discouraged from asking for what they really need from the Global Fund. The word is out, and it's often reinforced by Western diplomats at country level -- don't ask for too much, because the Global

Fund just doesn't have the resources.' Consequently, 'governments are reluctant to ask for what they really need, lest their whole proposal be turned down. They undershoot the level, in order to accommodate the G8 refusal to fund the Global Fund at the levels required' (quoted in Cook, 2006).

The inadequacy of the resources available to the Fund is dramatized by a proposal to expand the Fund's mandate beyond three specified diseases to financing comprehensive country health programs, thereby responding to a frequent claim that disease-specific programs undermine already fragile national health systems. In order to ensure the availability of the $40 minimum per capita cost of a basic health care system, as per the Commission on Macroeconomics and Health estimate, the Fund would need to be prepared to disburse US $28 billion per year, *even if* it did not provide any funds to countries where spending on health already exceeds that level and even if all recipient countries committed 3 percent of GDP to public spending on health care -- something many low-income countries are far from doing (Ooms et al., 2008).

The G8 record on debt relief is one of gradual and grudging, but consequential, response. Starting in the 1999 the G8 led the industrialized world in partially cancelling the debts of up to 40 countries, 32 of them in Africa, under the enhanced Heavily Indebted Poor Countries (HIPC) initiative. '[T]he amount of debt relief … was determined by eligibility thresholds which (according to public statements by [International Monetary] Fund and [World] Bank officials) were based on initial analysis… and then modified to suit political compromises amongst G7 creditors, balancing the need to include strategic G7 allies and their

desire to keep costs down'(Martin, 2004, p. 17). Eligibility thresholds are based on a ratio of anticipated export earnings to debt service obligations; partly because of undue optimism about export performance, HIPCs' progress toward meeting basic needs and reducing debt burdens has been inadequate (United Nations Secretary-General, 2006). Many saw only modest decreases in their debt service obligations; three – Mali, Mozambique and Bolivia – had actually experienced *increases* in these obligations as of 2005 (United Nations Department of Economic and Social Affairs, 2005, p. 148). Eligibility for debt cancellation was and is accompanied by the requirement that macroeconomic policies be approved by the World Bank and International Monetary Fund, creating what some observers view as a destructive reprise of earlier conditionalities aimed at integrating national economies into the global marketplace (Cheru, 2000; Cheru, 2001; Gore, 2004; Gaynor, 2005).

At Gleneagles, the G8 agreed to cancel an additional US $40 - $56 billion of debts owed by HIPCs to the World Bank, IMF and the concessional arm of the African Development Bank once they have reached their 'completion point' under the earlier initiative. This Multilateral Debt Relief Initiative (MDRI) was welcome and overdue, yet it is incomplete and compromised. Development assistance to recipient countries will be reduced by some or all of the amount of additional debt relief provided under MDRI (Joint World Bank/IMF Development Committee, 2005; Tomitova, 2005). The shell game may enter a new round if donor countries, mainly the G8, do not fully fund the requisite levels of debt relief through the World Bank, thus reducing the budget of the International

Development Association (IDA), the branch of the Bank that offers grants and below-market loans (Hurley, 2007). No mechanism exists to require participation of private sector creditors in multilateral debt relief initiatives. In addition, debt relief will not be extended to many countries that are not statistically desperate enough to qualify, despite high levels of poverty (only a minority of the world's poor live in HIPCs; see Labonte & Schrecker, 2004, p. 1665-1666) and high external debt burdens (Hanlon, 2000; Pearce, Greenhill, & Glennie, 2005).

The G8 have consistently failed, at least for public consumption, to address two fundamental questions. First, what justifies the definition of sustainability of external debt for purposes of determining eligibility for debt relief, and what is the ethical justification for the criteria chosen? The current criterion, based on a country's ability to service its debts from export earnings, prioritizes the interests of creditors. An alternative definition of sustainability instead prioritizes the ability of governments to undertake public expenditure to meet basic needs or achieve the MDGs, and then works backward to determine how much of the public budget, if any, should be devoted to debt repayment. Calculations using this approach indicate a need for far more extensive debt cancellation, for a much larger number of countries, than available under MDRI (UN Millennium Project, 2005; United Nations, 2005; Mandel, 2006). Exemplifying this approach is the New Economics Foundation proposal to structure debt cancellation around ensuring that debtor countries have available the resources needed to raise the living standard of their poorest residents to an 'ethical poverty line' of $3/person/day, as contrasted with the World Bank

poverty thresholds. On this basis, a total of 136 countries would require either complete or partial debt cancellation with a net present value of between $424 and $589 billion -- i.e., a fivefold increase relative to the amounts of debt cancellation available under the combined enhanced HIPC and MDRI initiatives, for a much longer list of countries (Mandel, 2006).

Second, should 'odious debts' incurred by repressive or corrupt governments without the consent of their subjects be regarded as collectable under international law (Khalfan, King, & Thomas, 2003)? The Commission for Africa cited an estimate 'that stolen African assets equivalent to more than half of the continent's external debt are held in foreign bank accounts' (Commission for Africa, 2005 p. 150); other estimates of capital flight from sub-Saharan Africa yield an even higher figure (Ndikumana & Boyce, 2003). In 2005, the G8 committed themselves to '[w]ork vigorously for early ratification of the UN Convention Against Corruption and start discussions on mechanisms to ensure its effective implementation' (G8, 2005), although as of July, 2008 Germany, Italy and Japan had yet to ratify the Convention. The Convention is potentially valuable because it binds parties to implement mechanisms to seize and repatriate illegally appropriated assets. Its effectiveness will depend on the commitment of governments whose subjects have been victimized; this is by no means assured (Rice, Campbell, & White, 2007), although the G8 could provide encouragement in several ways.[10] Even if ratified by all members of the G8 the Convention cannot substitute for a systematic initiative to define odious debts; to develop multilateral mechanisms to preclude their collection (by either public- or private-

sector creditors); and to ensure that cancelling debts run up by brutal and unaccountable regimes cannot be counted as development assistance, as is now the case.

On trade, although substantial opportunities exist to reshape trade policy in a way that is simultaneously and synergistically development-friendly and supportive of improvements in health, the challenges are formidable. The G8 claimed in 2002 that: 'The launch of multilateral trade negotiations by World Trade Organization (WTO) members in Doha … placed the needs and interests of developing countries at the heart of the negotiations' (G8, 2002). Similar rhetoric in following years culminated in the 2006 Summit's call 'for a concerted effort to conclude the negotiations of the WTO's Doha Development Agenda (DDA) and to fulfill the development objective of the Round' (G8, 2006, ¶1). Only days later, negotiations reached an impasse over the issue of agricultural subsidies, and a similar collapse terminated a subsequent round of talks in July, 2008 (Castle & Landler, 2008). Expectations for the Doha round may always have been too high (Ricupeiro, 2006), and the failure is perhaps not surprising, since introducing development goals into trade policy would mean a fundamental shift in the self-interested character of negotiations as they now exist (Stiglitz & Charlton, 2005). Nevertheless, the continued impasse underscores the need for G8 leadership – assuming, that is, that the rhetoric of commitment to integrating development objectives into trade policy is to be taken seriously. Collier has recommended that if the OECD countries as a whole were interested in unblocking WTO negotiations, they might jointly and unilaterally offer improved access to certain

sectors of their markets, in order to revitalize the negotiating process by way of an up-front incentive to developing country governments that is not conditional on subsequent bargaining -- in other words, adding an explicitly redistributive component (Collier, 2006c). No evidence to date suggests that this proposal has been taken seriously by the G7. On other trade issues, the lack of concrete proposals relating to the effects of intellectual property protection on access to essential medicines, and the fact that the United States has sought stronger, 'TRIPs-plus' intellectual property protection in its bilateral and regional trade agreements (Fink & Reichenmuller, 2006; United States Government Accountability Office, 2007), are not reassuring.

Conclusion: Whither (or wither?) the G8 and global health?

How much can be expected from the G8 in terms of policies that improve population health? Many international relations scholars think it unrealistic to expect that the foreign policies of powerful national governments will ever be driven by considerations other than national economic[11] and geopolitical interest. On this view, the G8 can be expected to adopt measures favourable to the health of those outside the industrialized world only when these will generate domestic political payoffs or enhance the competitive advantage of national economies and firms within their borders (Cerny's competition state).

It could therefore be argued that the most productive route for advocacy involves appeals to enlightened self-interest, notably by linking health with

security. Unfortunately, the claim that ‘better health for anyone, anywhere on earth, benefits everyone else’ (Global Forum for Health Research, 2002, p. 35) is vacuous. Although such developments as rapid, low-cost air travel and the global reorganization of food production have increased possibilities for disease transmission, direct danger to most people in high-income countries is probably limited to a small range of diseases, such as SARS and influenza, which can be easily transmitted through casual contact before symptoms develop. Not surprisingly, the 2006 Summit statement on infectious diseases was mainly concerned with planning for an influenza epidemic in the industrialized world. Arguably a more serious travel- and migration-linked threat is spread of resistance to antimicrobial drugs, which compromises treatments for a wide range of diseases (Okeke et al., 2005a; Okeke et al., 2005b; Zhang, Eggleston, Rotimi, & Zeckhauser, 2006); control of antimicrobial resistance may be one of the few true global public goods for health. However, only the occasional intrepid adventure traveler or tropical disease researcher is likely to be exposed to malaria. Most G8 residents have nothing to lose from the HIV epidemic in developing countries, from the social conditions that contribute to vulnerability to tuberculosis or HIV infection (Bates et al., 2004; De Vogli & Birbeck, 2005), or from the rapid increase outside the industrialized world in the prevalence of non-communicable diseases that were once mistakenly thought to be diseases of affluence (Adeyi, Smith, & Robles, 2007). The global distribution of health risks, in other words, parallels and reflects the distribution of economic (dis)advantage that is characteristic of contemporary globalization. Appeals to self-interest on this score

are unlikely to be credible either to leaders or to G8 electorates that understand, at least in general terms, the nature and extent of their risk exposure.

More fundamentally, the legitimacy of the G8 as a forum for making decisions that affect the health of the entire world is challenged with increasing frequency. For instance, a 2008 *Lancet* editorial called it 'preposterous and unjust to allow the leaders of eight countries that command 65% of the Gross World Product and represent only 13% of the world's population to assume the mantle of governance about issues that concern the entire world's economy, environment, health, and security'(MacDonald & Horton, 2008, p. 100, citations omitted). Ash has proposed building on the informal and partial inclusion of additional countries in recent Summits by adding China, India, Brazil, Mexico, South Africa and Indonesia to the club (Ash, 2008). Former Canadian Prime Minister Paul Martin and several international relations scholars (English, Thakur, & Cooper, eds. 2005; Thompson, 2005) have advocated further expansion into an L20 (or Leaders' 20), building on an existing forum for finance ministers by adding to the list of countries above Argentina, Australia, South Korea, Saudi Arabia and Turkey.

Bradford (2005) enthuses about this proposal as as a way of overcoming 'global economic apartheid,' but it might in fact deepen the gap between excluded and included states by leaving out (for example) all the Nordic countries and all of Africa except South Africa, a country that some argue now has a 'sub-imperial' relationship with the rest of the continent (Bond, 2004). Furthermore, the record of several countries proposed for inclusion, notably China, India and South

Africa, with respect to health disparities and SDH within their own borders is far from reassuring. China has marketized much of its system for providing health care, leading to increased difficulties in access for many and exacerbating problems associated with the rapid increase in economic inequality (see e.g. (Akin, Dow, Lance, & Loh, 2005; Office of the World Health Organization Representative in China, 2005; Dummer & Cook, 2007; Wong, Tang, & Lo, 2007). The main trade union congress in the United States, admittedly not an uninterested party, has documented a pattern of extremely long working hours, lack of labour standards, and hazardous working conditions leading to accidents that kill 140,000 workers every year (AFL-CIO, Cardin, & Smith, 2006). India actively displaces slum dwellers in order to create space for commercial development (Appadurai, 2000; Dupont, 2008), and its policy priorities have prompted the United Nations Development Programme (2005 p. 30-31) to observe that: 'Were India to show the same level of dynamism and innovation in tackling basic health inequalities as it has displayed in global technology markets, it could rapidly get on track for achieving the MDG targets'. South Africa's government for a long fiercely resisted publicly funded provision of antiretroviral therapy, and its macroeconomic policies have resulted in devastatingly high, and persistent, unemployment and poverty rates (Koelble, 2004; Streak, 2004; Kingdon & Knight, 2005).

It can be argued that the situations described are no worse than those that obtained in the G8 countries at comparable stages of development -- and, further, that they represent in part responses to the constraints created by globalization.

Domestic politics come into play as well, and governments in countries rich and poor alike respond to the preferences of domestic constituencies roughly in proportion to the political resources those constituencies can deploy -- resources that are, of course, augmented or diminished by globalization. The point here with respect to G8 reform is simply that expanding the club will not necessarily change the orientation of its member governments to issues of equity and distribution as they affect population health, either within or across national borders.

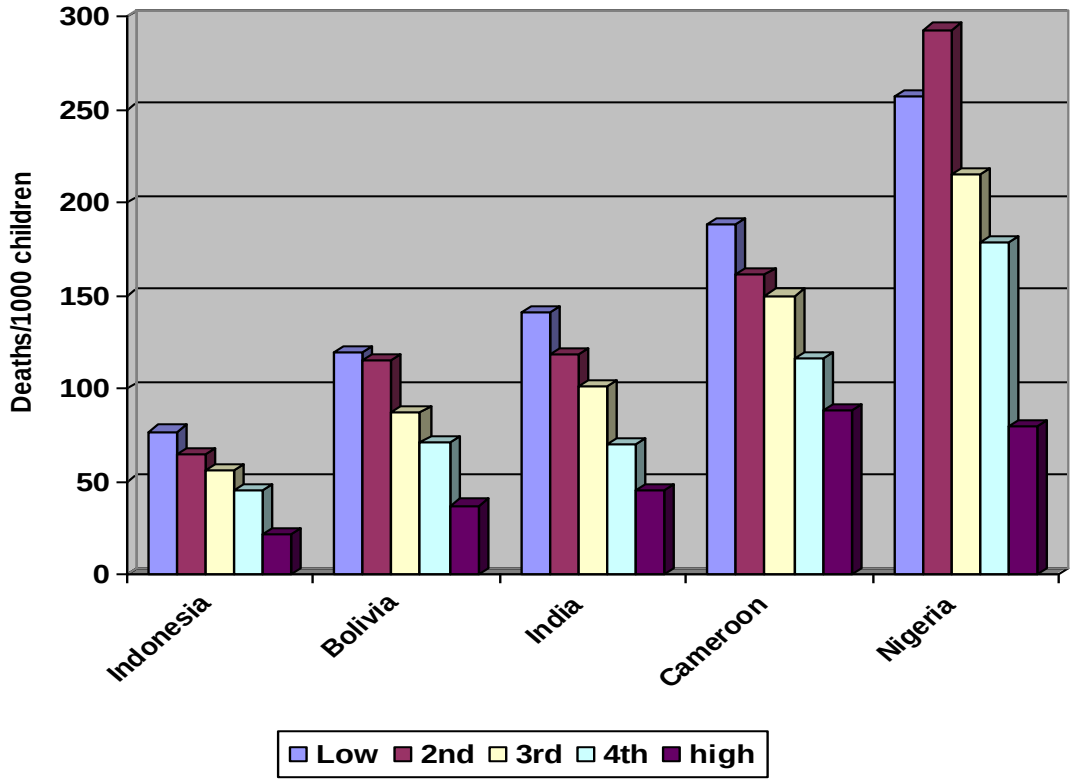
These observations are made without the detailed explication they deserve, but nevertheless suggest that progress toward policies that generate widely shared improvements in population health is likely to depend on effective advocacy, in the first instance at least at the level of domestic politics, of some form of global health ethic that is explicit about the need for priorities other than those of the global marketplace. Obligations related to the health of people outside a country's borders are recognized with increasing frequency (Labonté & Schrecker, 2007a), based on an expanding body of philosophical argument most closely associated with Thomas Pogge (Pogge, 2002; Pogge, 2005; Pogge, 2007, but see also Moellendorf, 2002). In my own view, the obligations in question must reflect the problematic nature of resource 'scarcities' for basic health-related purposes such as saving the lives of six million children under the age of five in developing countries every year (Bryce et al., 2005), against a background of unprecedented abundance (Schrecker, 2008). As Sachs has said, 'in a world of trillions of dollars of income every year, the amount of money that you need to address the health crises is easily available in the world' (Sachs, 2003).

One example suffices to illustrate the heuristic value of such a critical approach to scarcity. The author of a thoughtful critique of the politics behind the 2005 Gleneagles Summit characterized as 'astonishing' the US $169 billion in additional funds over the 2005-10 period that would be needed to bring the G7's development assistance spending up to the 0.7 percent of Gross National Income that has been a non-binding United Nations target since 1970 (Payne, 2006 p. 926). Subsequent developments underscore the hypocrisy of the rhetoric of making poverty history that permeated the 2005 Summit, and as noted earlier development assistance is only one of several channels of global redistribution, and its effects must be assessed in the context of overall global resource flows. Yet Norway, Denmark and Sweden have consistently met or exceeded the 0.7 percent target for two decades, and the amounts in question fade to insignificance beside the G8's annual military spending. A less familiar comparison breaks down the amounts needed to bring each G7 country's development assistance spending to the 0.7 percent target in terms of Big Macs per person per year, using *The Economist's* annual price comparison of that common gastrocommodity (Figure 3). The resulting amounts are modest, suggesting along with previously cited comparisons that astonishment is in the eye of the beholder, and beholder perceptions tend to vary widely among national contexts.

-- Insert Figure 3 about here –

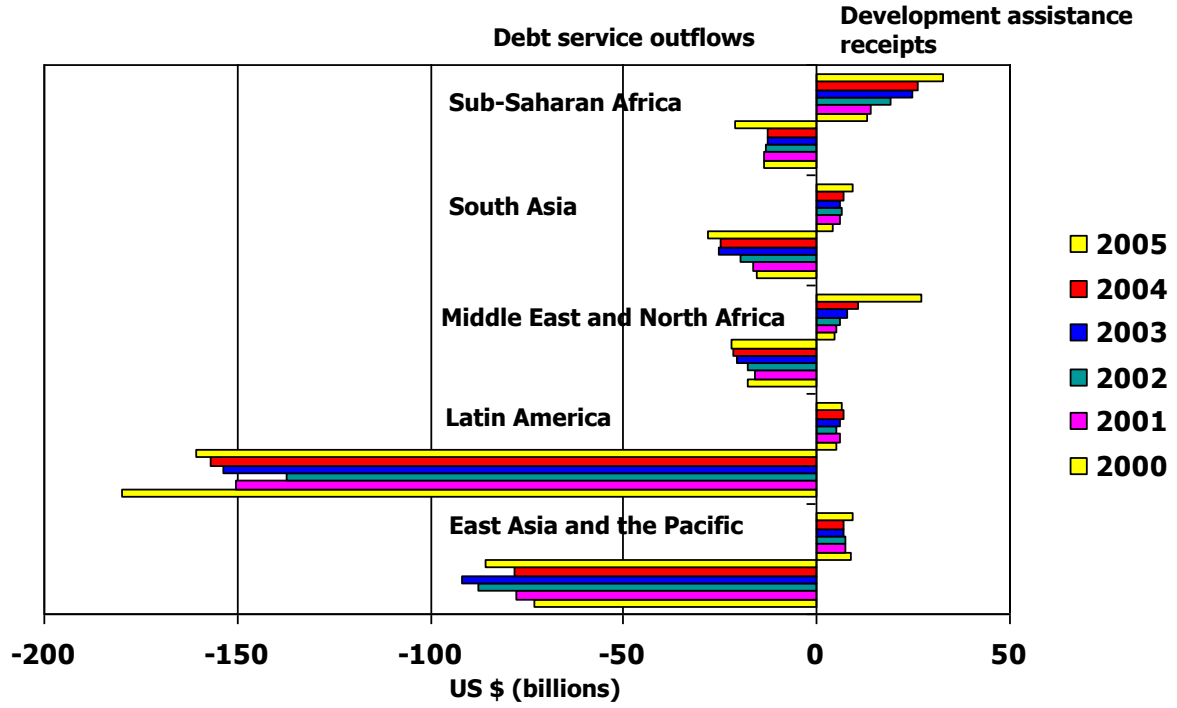
Philosophers do not make public policy, which is probably a good thing, and even using the language of global ethics often incurs the derision of one's colleagues. That derision may reflect a pragmatic appraisal of today's political climate, which at least within the Anglo-American countries with which I am most familiar could hardly be less hospitable. Although 'solidarity' is routinely invoked even by governments of the centre-right in discussing access to health services in continental Europe, a recent content analysis did not even find the term in Canadian health policy reform documents (Flood, Stabile, & Tuohy, 2002; Giacomini, Hurley, Gold, Smith, & Abelson, 2004). Further research is needed on the reasons for these international contrasts, their relation to globalization as mediated by domestic class structures and political allegiances, and the consequences for foreign policy as it affects health. Meanwhile, against the derision must be counterposed a long tradition of rigorous, engaged scholarship by such authors as Richard Falk and Susan George who insist on applying ethical standards to foreign policy and international relations.[12] Those of us who are committed to some form of global redistribution as ethically imperative based on its role in improving population health must draw strength from their examples and others', maintaining optimism as advocates and humanists while often undertaking a willing suspension of disbelief as social scientists.

Figure 1. Socioeconomic gradients in under-5 mortality, by household wealth quintiles, selected countries



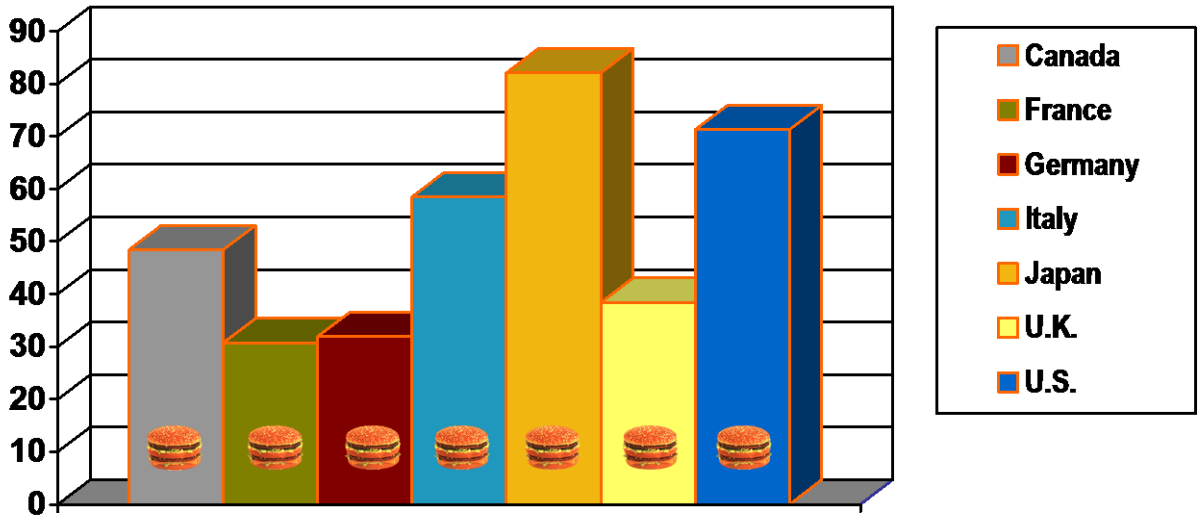
Source: Data from Gwatkin et al., 2007.

Figure 2. Debt service and development assistance, by region, 2000-2005



Source: World Bank, World Development Indicators [on-line], accessed March, 2008. Note that 'spikes' in development assistance for the Middle East and North Africa and sub-Saharan Africa in 2005 reflect one-off debt cancellation offered to Iraq and Nigeria, which counts as development assistance. As noted in the text, development assistance figures for 2006 and preliminary figures for 2007 show a reversion to pattern.

Figure 3. Additional cost to the G7 nations in 2007 of spending 0.7 percent of GNI on development assistance, in Big Macs per capita



Source: OECD Development Assistance Committee, 2008; Big Mac prices from Anon, 2007.

Notes

[1] This chapter draws on findings from several years of research collaboration with Ronald Labonte and David Sanders. I am indebted as well to many members of the Globalization Knowledge Network (Labonte et al., 2007) of the WHO Commission on Social Determinants of Health, for which I acted as Hub coordinator. All views expressed and conclusions drawn are exclusively my own unless attributed to cited authors.

[2] The Russian Federation achieved partial membership of the Group of 7 industrialized countries, making it the G8, in 1998 and full membership in 2003. However, Russia still does not participate in the periodic meetings of finance ministers that have become an important element of the Group's activities. Thus, some references in this chapter are to the G7, as appropriate to the context.

[3] Signs that this may be changing include the acquisition in 2006 of Canadian mining giant Inco Ltd. by Brazil's Companhia Vale do Rio Doce; the acquisition in 2008 of Ford Motor Company's Jaguar and Land Rover brands by India's Tata Motors; and an emerging pattern of Chinese direct investment in mining and oil and gas extraction. A valuable treatement discussion of the emergence of world-scale transnational corporations based in developing countries is provided by Goldstein, 2007.

[4] The importance of SDH, well established in the research literature (Evans & Stoddart, 1990; Marmot & Wilkinson, eds. 2006), was recognized in 2005 by the World Health Organization's establishment of a multinational Commission on Social Determinants of Health (World Health Organization, 2008).

[5] These define poverty with reference to incomes of US $1 and $2/day (in 1985 dollars, at purchasing power parity). These thresholds were originally developed based on a number of national poverty lines, rather than on any direct relation to the actual cost of a minimal market basket of goods in a particular national or subnational economy. This is just one of several grounds on which they are often criticized (for a detailed critique see Woodward & Abdallah, in press).

[6] Three of the MDGs are explicitly health-related, and four others directly address crucial social determinants of (ill) health. The MDGs have numerous shortcomings as policy objectives (Pogge, 2004; Gwatkin, 2005; Moser, Leon, & Gwatkin, 2005), yet have the merit of recognizing at least implicitly 'that many of the most devastating problems that plague the daily lives of billions of people are problems that emerge from a single, fundamental source: the consequences of poverty and inequality' (Paluzzi & Farmer, 2005, p. 12).

[7] For an eloquent description of this process as it has unfolded in Chile, based on extensive fieldwork, see Schild, 1998; Schild, 2000; Schild, 2007 and also Cooper, 1998.

[8] This is why smuggling was both a capital offence and a frequent axis of class conflict at the local level in eighteenth-century England (Winslow, 1975).

[9] Baunsgaard & Keen (2005) found that middle-income countries had been able to recover 45-60 cents of each dollar lost in tariff revenue, while low-income countries had recovered 30 cents or less of each dollar lost. Against the background realization that the revenue base in most such countries was already insufficient to support public provision of basic needs, the impact of such revenue

losses can best be understood by way of a thought-experiment in which national general government revenues in a high-income country like Canada or Sweden were reduced by somewhere between 40 and 70 percent over a relatively short period of time. Who would lose first, and worst, from the resulting cutbacks in service provision?

[10] Perhaps, in some cases, by linking eligibility for debt relief to specific asset repatriation initatives. It is, of course, difficult to envision the implementation of such conditionalities in the absence of ratification of the Convention by all members of the G8.

[11] In the context created by globalization, in which domestic economic interests are increasingly fragmented, it is more accurate to refer to the economic interests of politically decisive national pluralities or coalitions.

[12] Falk has epitomized the adherents of this position for two generations, from a crucial volume that condemned the conduct of US military forces in Vietnam (Falk, Kolko, & Lifton, eds. 1971) to more recent work on the relevance of human rights in international relations (Falk, 2000) and the need for 'a regulatory framework for global market forces that is people-centred rather than capital-driven' (Falk, 1996, p. 18). Scholar-activist Susan George, who first achieved international acclaim for a study of the political economy of hunger and nutrition-related illness (George, 1976), received the International Studies Association's first Outstanding Public Scholar award.

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